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ABSTRACT

The possible casues of abuse of mentally retarded persons in residential facilities are examined and a study of all reported abuse cases occurring in Alabama's residential facilities from January, 1984, to September, 1986 is reviewed. Fifty-seven confirmed cases of abuse were identified for further examination using facility records and system data bases. No significant differences were found for age, sex, or racial factors. The abused population tended to be higher functioning in Intelligence Quotient (IQ) level and adaptive behavior when compared to the general facility population. It is concluded that increased attention should be focused on teaching staff behavior management and aggression control techniques and that staff should be rotated to less stressful areas of the facility on a regular basis. Staff profiles suggested that staff who commit abuse were primarily direct care personnel who are less eeucated and less well paid than the general staff population. There was a greater tendency for abuse to be reported by professionals and administrative staff but to be committed by direct care staff. The need for assigning more professional and administrative staff to residential areas and for paying greater attention to reporting and tracking abuse is stressed. (CL)

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Presentation

to

American Association on Mental Deficiency

111th Annual Meeting

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"Abuse of Mentally Retarded Persons: Characteristics of the Abused, the Abuser, and the Informer"

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Mr. Rogan, fellow panelists, and fellow colleagues of AAMD: My presentation as indicated is entitled "Abuse of Mentally Retarded Persons: Characteristics of the Abused, the Abuser, and the Informer."

During the last 10 years, I have observed abuse and neglect firsthand as a worker in an institutional setting. I have dealt with abuse as a facility administrator whose duty it was to prevent, report, have abuse investigated, and then take appropriate action once abuse had been confirmed. And presently, I am in a central office administrative position where one of my functions entails reviewing all abuse cases which occur in state-operated facilities as well as in community residences. Reviewing all such cases over a period of approximately 7 years has afforded me a rare glimpse of resident abuse and has increased my concern that this problem must receive considerably more attention. The research literature provides scant attention to this area. At our conference this week, there are three other presentations

addressing this area. I feel as professionals we must examine why this area has received such limited attention.

First, I must state that I indeed feel a basic uneasiness about doing a presentation at a national conference on abuse in residential facilities in Alabama. It is much easier to discuss model programs in our facilities than it is to highlight administrative problems. It is much easier to get approval from your agency to present positive program aspects than it is to highlight critical issues of concern in your state plus get your state to pay your transportation to present. And, it is easier to get pure research-oriented articles published than it is to publish articles in mental retardation journals which address administrative issues and concerns such as abuse. I appreciate the opportunity that my state has given me to address these issues.

I feel that there are many reasons why we have not addressed these issues. First, we live in an age of litigation. In Alabama we have been involved in the Wyatt litigation for more than 14 years although this case was recently settled in a consent decree.

As with other states, you learn not to speak openly about problems in your residential facilities for fear that your words may be used out of context and possibly introduced as damning evidence in court.

Secondly, with increasing frequency, employees and administrators are being sued in their personal capacities and judgments awarded in these suits. This has set up a dual problem. On one hand, we have become overly concerned about risk management and by overcompensating in some ways for the problem, we may have actually confounded the problem. On the other hand, we have been fearful to highlight the problem out of concern that we would create suspicion and concern on behalf of parents and the general public which would in turn result in more litigation. In fact, public perceptions are influenced and shaped mainly by public exposes reported in the press. Although it is recognized that abuse is a widespread problem in general society, reports of such abuse typically receive limited coverage in the media. It is abuse

in our residential facilities which tends to be sensationalized in the media.

The employer who charges abuse also faces litigation from employees who are charged with abuse and by the employees' representatives. The employer, under customary rules, has the burden of proof. It is apparent when one reviews personnel actions resulting from resident abuse that this area is very complicated from a personnel standpoint. Personnel actions often reflect the philosophy of the system and range from a "fire-the-bastards attitude" as indicated by Sundram to a philosophy that it is easier to just let them resign quietly. Unfortunately, those who resign often are then re-employed by another system only to commit abuse once again.

It appears that the majority of our efforts in dealing with abuse in residential facilities for persons with mental retardation has been expended on dealing with the outcome of abuse and the personnel actions which have resulted. Even more limited has been the attention given to the causes of abuse and to strategies to prevent abuse and neglect.

Therefore, I would like to first focus on the causes of abuse. Although not conclusive, I feel that the following causes contribute significantly to the majority of abuse in our facilities.

First, as I previously indicated, although the population in public residential facilities has significantly decreased, those who remain in these facilities provide significantly more of a challenge from a behavioral management standpoint. For the most part, our facilities have as their primary purpose that of serving individuals who are a danger to themselves or others. If this were not the case, these individuals would have already been placed in community residences.

Secondly, there is an inability for management to have much influence in determining whom they can hire. In many states, direct-care workers are selected based on a score on a written test which in turn provides a ranking for purposes of hiring. Often there is only limited investigation of an individual's background,

and rarely are individuals screened and removed from such registers.

Third, staff training in many cases is deficient. Having staff receive the necessary training which would enable them to effectively do their job is considered a luxury. Due to high turnover rates, it is necessary to put staff immediately into vacancies rather than provide them with necessary training.

Fourth, there has not been enough attention given to environmental factors and their effects on resident abuse and neglect. In many cases, staff are relegated to uninteresting tasks for extended periods of time while providing services in unstimulating environments. The stress related to working in such environments is well documented in the research literature.

Fifth, there are limited means for public sector agencies to control staff behavior. On one hand, we cannot reinforce behavior through recognized means used in the private sector such as cash bonuses, days off, or other meaningful reinforcers. On the other hand, attempts to provide discipline for neglect and abuse are

often blocked by arbitrators, civil service commissions, unions, EEOC commissions, or other groups which must balance the rights of the employees against the rights of the residents of these facilities. As Armstrong indicated in an editorial in Hospital and Community Psychiatry, "Often facility directors have to get at least as much, if not more, evidence to discipline someone as they would need in a criminal prosecution."

Sixth, since it is so hard to prove abuse and uphold charges of abuse, there is a natural reluctance to report abuse. The employee reporting abuse cannot be guaranteed confidentiality since, at some point, their evidence will be necessary, and in the interim, they must often continue to work with the abuser. In many cases, this results in an attitude that it is easier to ignore rather than report abuse, particularly minor cases.

Seventh, we have not taken a systems approach to abuse. It is necessary to determine if we have in place effective controls to identify problem areas in our facilities. It is necessary to determine if a preponderance of these cases is occurring in

specific sections of our facilities. I will return to this later when I discuss specific implications of my study.

Finally, it is necessary, as I have previously indicated, to focus on methods to prevent abuse. If possible, we must identify specific resident groups who are at risk of abuse and employees who potentially might commit abuse.

With this in mind, the present study was undertaken. It is necessary to first detail how the results of this study may be used. With regards to resident characteristics, it provides information concerning at-risk groups, and it provides direction for targeting our preventive efforts.

With regards to individuals who commit and report abuse, it provides us some preliminary information on their characteristics. Developing such profiles should enable us to identify high-risk groups for training purposes and to initiate preventive strategies. The intent was not and should not be to use this information for hiring decision or for discriminating against one employee group versus another in job assignments or other related job functions.

The study was initiated by examining all reported abuse cases which occurred in Alabama's residential facilities from January of 1984 to September of 1986. Our policy requires all cases of unexplained injuries or of suspected or actual abuse to be investigated by either internal security or external department investigators depending on the nature and severity of the incident. During this period of time, there were 589 cases reported.

We then selected those cases from this total in which it was confirmed from our investigations that abuse actually occurred. There were 57 confirmed cases of abuse during this period of time. The breakdown of these cases reflects 39 occurrences of physical abuse, 10 cases of verbal abuse, 4 cases of sexual abuse, 3 cases of inappropriate application of behavioral control techniques, and 1 case of neglect. Of these cases, 42 cases were at facilities which were larger than 325 beds while the remaining 15 cases were at facilities which ranged from 200-225 beds.

Following our identification of these 57 confirmed cases of abuse, we proceeded to identify for each case the individual who

was abused, the individual(s) who committed abuse, and the individuals(s) who reported abuse.

Using facility records and system data bases, we then examined variables of interest. For the abused population, this included male/female ratios, age factors, racial characteristics, mean years at the current facility, I.Q. levels, adaptive behavior levels, and Adaptive Behavior Scale profiles.

For staff we examined male/female ratios, age factors, racial characteristics, years of service, classification, marital status, years of education, evaluation scores, salary, and shift.

In order to compare these factors to the general population, when possible we computed this same data for approximately 1300 residents and 2400 staff which comprised our general population. When comparing sample data to the general population, we computed appropriate analyses where feasible. In most cases, this consisted of a chi-square goodness of fit analysis.

With regards to residents who were abused, we found that, of the abused sample, 56% were males and 44% were females. When

compared to the general population, this difference was not significant. However, closer examination of individual facilities reflects that the number of males abused ranged from 46% to 86%.

When examining age factors, we found no significant differences although the abused sample tended to be slightly younger. The average age of the abused sample was 37 years old as compared to the average age of the general population which was 39. Those who were abused ranged in age from 10 to 62.

With regards to racial factors, 78% of the abused population were white and 22% were black. This compares favorably with the general population in which 69% were white and 31% were black. Again, there were not significant differences.

The mean years in which the abused group were at the facility was 10 years as compared to the population average of 12 years. Length of time at the facility ranged from two weeks to 40 years.

With regards to I.Q. level, there was a significant difference at the .01 level of significance. The abused population tended to be higher functioning when compared to the general population. In

the abused group, 13% were mild and above as compared to 3% in the general population, 15% were moderate as compared to 9% in the general population, 16% were severe as compared to 20% in the general population, and 56% were profound as compared to 68% in the general population.

When examining adaptive behavior, we also found a significant difference at the .01 level of significance. The abused sample again tended to be represented to a greater degree at the higher functioning levels. In the abused group, 15% were at the mild functioning level or above as compared to 4.3% in the general population, 13% of the abused population were moderate as compared to 10% in the general population, 25% of the abused population were severe as compared to 25% in the general population, and 47% of the abused population were profound as compared to 60% in the general population.

We then examined AAMD ABS profiles. We obtained these profiles by averaging ABS domain scores for each resident and then converting those average domain scores to percentiles by using the

conversion table for the age range in which the average age of the group fell. The table used was for ages 30-49 years.

In examining these results, we found that scores fell between approximately the 18th to the 44th percentile; therefore, clients were functioning in the severely mentally retarded range of adaptive functioning.

On Part 2 of the AAMD ABS, the profile reflects that 9 of the 13 domains fall within the "significantly maladaptive range" which is at the 85th percentile or above. The four remaining domains fell between the 75th and 85th percentile and included the following domains: antisocial behavior, untrustworthy behavior, withdrawal, and psychological disturbance.

In summary, with regards to the abused population, we found that the majority were males (56%), the majority were white (78%), the average age was 37 years, and the average years of institutionalization at their current facility was ten years. None of these results was significant when compared to the general population. Results which proved significant reflected that the

abused group was higher functioning with regard to both I.Q. and adaptive behaviors.

When examining ABS profiles, the abused group scored in the significantly maladaptive range at the 85th percentile or above on 9 of the 13 domains.

From this data, we can begin to develop strategies for preventing abuse and neglect in residential facilities. Based on resident profiles that were developed, individuals who scored in the moderate or above range in I.Q. and adaptive behavior and who scored in the significantly maladaptive range on the AAMD-ABS Section II should be considered a high risk group for abuse.

Implications of these results suggest that residential areas housing these individuals should be examined closely. There should be an effort to provide increased training opportunities focusing on behavior management and aggression control techniques. Attention should be given to assisting staff in handling and coping with client maladaptive behaviors. Staff should be selected to

work in areas with clients who meet this profile based on demonstrated ability to handle such clients in an appropriate and effective manner.

Since it has been demonstrated that the majority of abuse is committed in these residential areas, it is also suggested that staff be rotated to less stressful areas of the facility on a regular basis. Staff should be encouraged to discuss work concerns with supervisory staff. Employee assistance programs should be developed and employees encouraged use such programs. In these areas, more attention should be given to causes of stress on employees such as mandatory overtime. Requests by employees for transfers should be given serious consideration if the employees feel that their situations justify transfers.

Staff and residents in these areas should also receive extensive instruction on resident rights and on procedures for reporting abuse. An advocate should be available to assist residents with their concerns including reporting abuse.

These residential areas also warrant consideration of special training pools and of the use of a buddy system. Such a system would pair more experienced administrative, professional, and direct-care staff with less experienced staff in these areas. This would encourage on-the-job training and formal and informal discussion concerning proper procedures for enhancing normalization and decreasing inappropriate behaviors. Additionally, this strategy would encourage staff to seek assistance before their frustrations result in abuse.

In analyzing staff characteristics, it appeared that committing and reporting staff are slightly younger than the general population. Average age for staff committing abuse was 35.55 years, reporting was 36.82 years, while the general population was 38.66 years.

With regards to years of service, staff committing and reporting abuse had less seniority than the general population. The general population had 6.79 years of service, while staff

committing abuse had 5.37 years, and staff reporting abuse had 6.08 years of service.

Of the staff committing abuse, 84% were direct-care nonprofessionals while this group accounted for only 44% of those reporting abuse. Twenty-two percent of the cases were reported by professional staff and 24% by administrative staff.

In reviewing marital status, 54% of those committing abuse were single and 46% married, while this was reversed with regards to those reporting abuse, 47% were single and 53% were married.

Staff reporting abuse tended to be higher educated with 14.53 years of education while those who committed abuse had 12.29 years. There were also significant differences in salary between reporting and abusing staff. Average salary of the general population was $608.00 biweekly while abusing staff received on the average $494.00. Reporting staff exceeded the general population with $667.09 biweekly.

In examining staff evaluation scores for the last three years, it was found that staff committing abuse scored significantly lower

on their performance evaluations than reporting staff scored. Average scores for committing staff on a 5 point scale were 3.20 as compared to 3.79 for those who reported abuse.

An analysis of male/female ratios reflects a significant finding at the .01 level. An examination of the data suggests that males are involved in committing abuse much more frequently than would be expected. Males committed abuse in 61% of the cases and reported it in 31%. Only 36% of the general population were males.

With regard to race, there was no significant difference with regards to who commits abuse. However, whites significantly reported abuse more than would be expected based on the general population. These results are most likely reflective of classification, salary, and education.

An examination of shift factors reflects that 40% of abuse occurs on the first shift, 46% on second shift, and 13% on third.

In summary, staff profiles reflect that staff who commit abuse are primarily direct-care staff who are less educated and lower paid than the general population. The majority are male (84%) and,

for the most part, they have scored lower than the general population on their performance evaluations.

The majority of staff reporting abuse were female, were professional and administrative staff, scored significantly higher on their performance evaluations than those committing abuse, and were much higher paid ($60 biweekly) than the general population and the staff committing abuse ($175 biweekly).

Implications of these results suggest that we must pay considerably more attention to our staffing procedures. As indicated, there is a greater tendency for abuse to be reported by professionals and administrative staff but to be committed by direct-care staff. More professional and administrative staff must be assigned to residential areas and given more direct-service roles. They must be available in residential areas where they can better assist direct-care staff to deal with resident behaviors which result in abuse.

All staff members and especially direct-care staff must receive comprehensive training in identifying and reporting abuse

and neglect. This training must be scheduled periodically to reinforce staff behaviors. It should be remembered that staff who committed abuse had an average of 5.37 years of seniority. They were not new staff; they had not just graduated from training.

These statistics also reflect that, although 60% of reported abuse occurs on the second and third shift, only 44% is reported on these shifts. The majority of reports are filed by professionals and administrators on the first shift who are reporting the results of the abuse, the bruises, and the injuries. We must scrutinize our deployment of professionals and administrators on second and third shifts where we typically only maintain a skeleton staff of these individuals although this is the time that the majority of residents are on the living units.

From a systems perspective, it is clear that our first priority must be to ensure that we have effective systems in place such as policies, procedures, and administrative safeguards to combat abuse. We must ensure that mechanisms are in place which

foster positive regard for resident rights on the part of employees and management.

Secondly, staff training must receive a higher priority. Those who receive the least amount of training prior to placement on the job are the same staff who commit the majority of abuse--the direct-care staff. Too often this training is considered a luxury when, in fact, it is a necessity if we are to make staff more effective in managing resident behaviors and thereby reducing abuse.

Third, we must give more attention to reporting and tracking abuse. Data regarding location of where abuse occurs, clients and staff involved, nature of abuse, and other related factors may assist us in targeting our preventive efforts more efficiently. If surveyed, many states would be unable to report even the number of cases of abuse reported in their system not alone the nature of abuse or at which facility abuse is primarily occurring. It is not unusual that the majority of abuse is occurring at a single

facility. This may be the result of a more aggressive reporting procedure rather than a more abusive staff.

Finally, we must focus on ways to reinforce positive behavior. Too often we focus on the ends rather than the means. Staff should be encouraged for treating clients with positive regard. Systems should be in place for recognizing staff performance. Assistance programs should be available to assist employees in doing a better job. Staff should be permitted to request and receive special or remedial training which does not reflect poorly on their job performance.

In conclusion, I feel that this area must receive more attention. Research cannot continue to focus only on the outcome of abuse but must address the causes. By focusing on the causes and the characteristics of those who are abused and those who commit and report abuse, we can gain insights into techniques to prevent abuse. It is hoped that this study will facilitate that effort.

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